Complete Summary

GUIDELINE TITLE

American Gastroenterological Association medical position statement: clinical use of esophageal manometry.

BIBLIOGRAPHIC SOURCE(S)

Pandolfino JE, Kahrilas PJ. American Gastroenterological Association medical position statement: clinical use of esophageal manometry. Gastroenterology 2005 Jan;128(1):207-8. PubMed

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: An American Gastroenterological Association medical position statement on the clinical use of esophageal manometry. American Gastroenterological Association. Gastroenterology 1994 Dec;107(6):1865.

According to the guideline developer, the Clinical Practice Committee meets three times a year to review all American Gastroenterological Association Institute (AGAI) guidelines. This review includes new literature searches of electronic databases followed by expert committee review of new evidence that has emerged since the original publication date.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Conditions for which esophageal manometry may be indicated, such as:

- Esophageal motility disorders (e.g. dysphagia or achalasia)
- Esophageal motor abnormalities
- Conditions requiring placement of intraluminal devices (e.g., pH probes)
- Conditions requiring antireflux surgery

GUIDELINE CATEGORY

Assessment of Therapeutic Effectiveness
Diagnosis
Evaluation
Management

CLINICAL SPECIALTY

Gastroenterology

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To assist physicians in the appropriate use of esophageal manometry in patient care

TARGET POPULATION

- Adults with esophageal syndromes, such as achalasia or dysphagia
- Adults being considered for antireflux surgery if uncertainty remains regarding the correct diagnosis.
- Adults requiring placement of intraluminal diagnostic devices

INTERVENTIONS AND PRACTICES CONSIDERED

Esophageal manometry

MAJOR OUTCOMES CONSIDERED

- Utility of esophageal manometry in clinical practice
- Impact of manometry on management decisions in gastroesophageal reflux disease
- Prognostic value of manometric findings with regard to postoperative outcome in patients with esophageal motility disorders (i.e., control of reflux symptoms and incidence of symptomatic dysphagia)

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The guideline developers performed a literature search for all English-language articles dealing with manometric evaluation of the esophagus from 1994 to 2003. The databases searched included MEDLINE, PreMEDLINE, and PubMed using general terms related to manometric technique (sleeve, topography) and equipment (water perfused, solid state), esophageal symptoms (dysphagia, chest pain, heartburn), esophageal disorders and procedures (gastroesophageal reflux disease, achalasia, diffuse esophageal spasm, nutcracker esophagus, hypertensive lower esophageal sphincter [LES], nonspecific motor disorders, ineffective esophageal motility, fundoplication, myotomy, dilation), and terms focused on esophageal motor function (upper esophageal sphincter, lower esophageal sphincter, esophageal body, peristalsis). Additional references were identified from references of reviewed manuscripts.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The data used to formulate these recommendations are derived from the data available at the time of their creation. Ideally, the intent is to provide evidence based upon prospective, randomized, placebo-controlled trials; however, when this is not possible the use of experts' consensus may occur.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

Guideline developers reviewed published cost analyses.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The document was approved by the American Gastroenterological Association Clinical Practice Committee on October 2, 2004, and by the American Gastroenterological Association Governing Board on November 7, 2004.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

These recommendations are an update from previous recommendations published in 1994 and represent the results of meticulous research into areas of controversy from the previous policy statement. In addition, new techniques have evolved that may improve and complement manometric diagnosis. Thus, these recommendations also take into account how these new technologies may alter clinical practice.

Indications for Esophageal Manometry

1. Manometry is indicated to establish the diagnosis of dysphagia in instances in which a mechanical obstruction (e.g., stricture) cannot be found. This is particularly important if a diagnosis of achalasia is suspected. However, given the low prevalence of achalasia in patients with esophageal symptoms, more common esophageal disorders should be excluded with barium radiographs or endoscopy before manometric evaluation.
2. Manometric techniques are indicated for placement of intraluminal devices (e.g., pH probes) when positioning is dependent on the relationship to functional landmarks, such as the lower esophageal sphincter.
3. Manometry is indicated for the preoperative assessment of patients being considered for antireflux surgery if there is any question of an alternative diagnosis, especially achalasia.

Possible Indications for Esophageal Manometry

1. Manometry is possibly indicated for the preoperative assessment of peristaltic function in patients being considered for antireflex surgery.
2. Manometry is possibly indicated to assess symptoms of dysphagia in patients who have undergone either antireflux surgery or treatment for achalasia.

Esophageal Manometry Not Indicated

1. Manometry is not indicated for making or confirming a suspected diagnosis of gastroesophageal reflux disease.
2. Manometry should not be routinely used as the initial test for chest pain or other esophageal symptoms because of the low specificity of the findings and the low likelihood of detecting a clinically significant motility disorder.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

The recommendations are based upon the interpretation and assimilation of scientifically valid research, derived from a comprehensive review of published literature.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate clinical use of esophageal manometry

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The Medical Position Statements (MPS), developed under the aegis of the American Gastroenterological Association (AGA) and its Clinical Practice Committee (CPC), were approved by the AGA Governing Board. The data used to formulate these recommendations are derived from the data available at the time of their creation and may be supplemented and updated as new information is assimilated. These recommendations are intended for adult patients, with the intent of suggesting preferred approaches to specific medical issues or problems. They are based upon the interpretation and assimilation of scientifically valid research, derived from a comprehensive review of published literature. Ideally, the intent is to provide evidence based upon prospective, randomized, placebo-controlled trials; however, when this is not possible the use of experts' consensus may occur. The recommendations are intended to apply to healthcare providers of all specialties. It is important to stress that these recommendations should not be

construed as a standard of care. The AGA stresses that the final decision regarding the care of the patient should be made by the physician with a focus on all aspects of the patient's current medical situation.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1994 Jul 15 (revised 2005 Jan)

GUIDELINE DEVELOPER(S)

American Gastroenterological Association Institute - Medical Specialty Society

SOURCE(S) OF FUNDING

American Gastroenterological Association Institute

GUIDELINE COMMITTEE

American Gastroenterological Association Clinical Practice Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Authors: John E. Pandolfino; Peter J. Kahrilas

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

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GUIDELINE AVAILABILITY

Electronic copies: Available from the American Gastroenterological Association Institute (AGAI) Web site.

Print copies: Available from American Gastroenterological Association Institute, 4930 Del Ray Avenue, Bethesda, MD 20814.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- American Gastroenterological Association technical review on the clinical use of esophageal manometry. Gastroenterology 2005 Jan;128(1);209-24.

Electronic copies: Available from the American Gastroenterological Association Institute (AGAI) Web site.

Print copies: Available from American Gastroenterological Association Institute, 4930 Del Ray Avenue, Bethesda, MD 20814.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on June 30, 1998. It was verified by the guideline developer on December 1, 1998. This NGC summary was updated by ECRI on January 31, 2005.

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